Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July - September 2005

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Children's Administration Child Fatality Report

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INTRODUCTION

This is the July – September 2005 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature as required by RCW 74.13.640. Passed during the 2004 Legislative Session, HB 2984 (RCW 74.13.640) requires the department to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This Quarterly Child Fatality Report summarizes the five reviews that were completed during the third quarter of 2005. Three of these cases were fatalities that occurred in 2004 and two were fatalities that occurred in 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan to address the identified issues. A review team can be as few as two individuals on cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may be the result of abuse and/or neglect by a parent or guardian.

The Executive Child Fatality Review is a special review convened by the Children's Administration's Assistant Secretary. The Executive Child Fatality Review may be requested in cases where a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case or in a licensed facility. In the Executive Child Fatality Review, members of the review committee are individuals who did not have any involvement in the case and represent areas of expertise that are pertinent to the case. Committee members may also include legislators or others as determined by the Assistant Secretary.

It is often many months following the death of a child before the fatality review is completed. This is due to Child Fatality Reviews requiring a multi-agency effort in gathering complete reports and findings. It is necessary to wait until all information is compiled in order to ensure a thorough review of the case, even when this means having an extended timeline for completion.

The chart below provides the total number of fatalities reported to CA with the number of reviews completed and pending for 2004 and 2005. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for 2004 and 2005			
Year	Total Fatalities Reported to Date	Completed Fatality Reviews	Pending Fatality Reviews
2004	50	30	20
2005	32	3	29

The numbering for the Child Fatality Reviews in this report begin with #04-32. This indicates the fatality occurred in 2004 and is the 32nd report completed for that year. The number is not assigned until the Child Fatality Review and report by the CPS Program Manager are completed.

The reviews included in this quarterly report discuss fatalities that occurred in the following Regions:

1 report is from Region 1—Spokane
1 report is from Region 2—Ellensburg
2 reports are from Region 3—Bellingham and Lynnwood
1 report is from Region 4—Kent

In addition to the quarterly Child Fatality Reviews, CA will be completing an Annual Child Fatality Report which will provide statistical information as well as issues and recommendations from reviews on child fatalities that occurred throughout the entire year. The next annual Child Fatality Report will be for the year 2003.

Child Fatality Review #04-32
Region 4
Kent Office

Case Overview

This nine-month-old Caucasian male was found unresponsive in his crib at his daycare home on September 7, 2004. Efforts to revive him were unsuccessful. The autopsy revealed a previously undetected congenital heart defect.

This care provider had a daycare in her home, and was first issued a family child care license on August 5, 1997. The licensed was closed March 27, 1998 when she moved to a new residence. The inspection process at the new home began May 29, 1998, and the license was renewed fully on July 14, 1998.

Child Protective Services (CPS) received a report of possible physical neglect on September 22, 1998. A mother who had taken her three children to this daycare home complained the provider leaves young children downstairs unsupervised. Both the licensor and a Division of Licensed Resources (DLR)/CPS investigator responded. The licensor found the provider was meeting standards because she was using an audio monitor while upstairs. The investigator concluded the allegations of physical neglect were unfounded.

A second report of possible physical neglect was received May 28, 1999. This was an incident in which two little boys allegedly touched a three-year-old girl inappropriately. Both Division of Child Care and Early Learning (DCCEL) and DLR/CPS staff responded and investigated. The investigation was unfounded for physical neglect. The incident happened when the daycare provider had left the room for a short time, and was within hearing distance. Concerns were also noted that the parents in the daycare home were frequently watching television, the children watch videos too often, and the provider may rely too much on a baby monitor as a substitute for supervision.

On May 15, 2001, a mother reported an incident that was screened as a licensing complaint. Her then 20-month-old had scratches on his bottom when she changed his diaper subsequent to his stay at the daycare home. While the child's doctor thought there was no evidence of child abuse and/or neglect, it could have been caused by a fingernail, or contact with some other object. The licensor noted "findings for care and nurture are inconclusive."

The King County Medical Examiner reported on September 7, 2004 the death of a nine-month-old infant in the home of this provider. The baby was in his crib at the daycare. When the daycare provider went to wake him up, she found the child deceased. This referral was accepted for investigation because the medical examiner did not believe the cause of death was from Sudden Infant Death Syndrome (SIDS). Subsequently the cause of death was confirmed to be due to a heart arrhythmia, related to a congenital birth defect of the heart. The manner of death is natural.

The DLR/CPS Investigative Assessment concludes that the allegations of negligent treatment and/or maltreatment are founded. The following is a summary from the Investigative Assessment dated June 2, 2005.

“On Sept. 7, 2004, 20lb, 9 month old was confined to a padded crib which was placed against a wall, for approximately 5 to 6 consecutive hours. For approximately 3 of those hours, the child, who was wearing sweat pants and a shirt, was swaddled in a blanket. During that time the daycare provider never picked the child up out of the crib, and she never fed him food or provided him any water or anything to drink. She intended to give him a bottle on two separate occasions but got distracted and forgot. According to the daycare peer, 5 year-old female, the child was crying all day. This account is consistent with daycare provider’s report that because of his feeding schedule he would have cried all day if he had not received food or water. In addition, based on what his mother reported about his level of activity and his inability to remain in a crib all day, it is likely that [the child] was also crying because he was confined and wanted to get out of the blanket and out of the crib.

Despite the fact that the mother warned the daycare provider that day that [the child] was teething and not feeling well, the daycare provider did not provide the baby with even the basic level of care and attention that a 9 month old requires and which is mandated by state minimum licensing regulations.

In addition to the lack of food, water, nurturing and care, swaddling the child, an extremely active, big, 9 month boy, and confining him in a crib insulated by plastic mats on a hot day, created an environment where he was at serious risk of physical and emotional harm. The fact that he was sweaty when he was found, and that the crib mattress was soiled from his perspiration primarily in the area in the top left hand corner suggests that he was likely struggling in that area and trying to get out of the crib. The presence of the bumpers created a significant risk of suffocation, and it also increased the heat and restricted the flow of air. He was found on his stomach, which means he rolled himself over because the daycare provider maintains that she placed him on his back. Even though the Medical Examiner said that they could not prove suffocation or smothering, the evidence shows that the child was in an environment where there was a significant risk of smothering or suffocation. He was also at risk of dehydration. All of these factors combined demonstrate that his basic needs were not met and that he was not adequately supervised. Providing adequate food and supervision is necessary for a child's health, welfare and safety. Failure to provide food and supervision showed a serious disregard of the consequences to the child and constituted a clear and present danger to his health, welfare and safety."

The family child care home license was suspended in September 2004 and revoked on May 31, 2005.

Issues and Recommendations

I. Quality Social Work

A. The thoroughness and clarity of this investigation is exceptional.

Recommendation: *It would be helpful to amend the Division of Children and Family Services (DCFS) Investigative Risk Assessment form to include what DLR has added, a section on persons interviewed and records reviewed, etc.*

Child Fatality Review #04-33
Region 3
Lynnwood Office

Case Overview

This 12-year-old Caucasian male died on July 21, 2004 due to an automobile accident unrelated to the focus of the Child Protective Services (CPS) investigation. The parenting concerns in this family were related to the father. This incident occurred while the child was visiting in another state with the mother's family. There was no indication from the Idaho police of any neglect or wrongdoing involved in this accident.

The primary issue which brought this family to the attention of CPS was the father's alleged alcohol issues and possible domestic violence. The father was arrested for misdemeanor assault 4 in the state of Oregon. This involved an incident with his girlfriend. The father had been drinking, and the children were with him at the time.

The Investigative Assessment states that the father was offered a substance abuse evaluation by the social worker on July 24, 2004, which he refused.

This family first came to the attention of the Department in August of 2003 when Washington CPS was notified by Oregon CPS of an incident which occurred in their state. The incident involved the father and his girlfriend, his 13-year-old daughter, nine-year-old son, and the now deceased son, then 12-years-old. The father was on vacation with his children and girlfriend, and his girlfriend's children. There was an argument between the father and his girlfriend, both of whom had been drinking heavily. It was alleged that an altercation followed, and the father threw the girlfriend into the wall, resulting in a bleeding abrasion on her right forearm. The father was booked and released in Oregon on misdemeanor charges of assault and harassment. This was taken as an information only referral and no action was taken by Washington CPS.

In March of 2004, CPS received and accepted for investigation a complaint called in by the mother of these three children. The mother was living in Idaho at that time, having left the father and children where they were living in Lynnwood. The mother’s concern was that she had received a "hysterical" call a month prior from her oldest child. The oldest child reported to her mother that her father had pushed her into a wall, causing a burn mark. The child continued to state that her father was staying away all night with his girlfriend, and not leaving a phone number. The police had been called on the night of this incident, and they had given her father a "warning." The children all wanted to go to Idaho to live with the mother.

This referral was assigned for investigation, and the assigned CPS worker interviewed the oldest child at school. She reported that she had had a bruise from the incident described above. She said she and her two siblings were left alone one time until 6 AM, but said that she did have cell numbers for her father. She also stated that her father's behavior was unpredictable, and he

frequently yelled at the children. She indicated she and her siblings wanted to live with their mother. The findings from this investigation were inconclusive and no intervention occurred.

On April 2, 2004, the mother once again called CPS to report her concerns about her children and their father's care of them. She reported that her 12-year-old had told her on the phone that his father "threw him against the wall" because his siblings "told on him" that he was not behaving when all three children had been home sick all day. The argument was about a broken chair. There were evidently no injuries to the children. The referral was taken as "information only," as there were no injuries.

The mother called a few weeks later and said she was in Washington and was attempting to get law enforcement or CPS to "take action" against her ex-husband so she can have the children live with her.

The mother was apparently successful in getting the children to return with her to Idaho after this. There was no further case activity until late July 2004 when the Sheriff's Office in Idaho City, Idaho (mother's residence) called to say the 12-year-old had died in an auto roll-over accident in Idaho. While staying with the mother's parents, the 12-year-old had been a passenger in a car driven by a friend, along with the oldest child and a niece. The newspaper article reported the 12-year-old had been wearing a seat belt but was said to have slipped out. The accident was investigated by the Idaho State Police. The mother told the social worker who called her about this that although the father still had legal custody of the children, it was agreed they would live with the mother and her parents in Idaho.

In a follow-up call to the maternal grandmother in December of 2004, it was reported that the mother had returned to Washington with the remaining siblings and has been living there. She reported the children are doing well.

Issues and Recommendations

No issues or recommendations were identified during the review process.

Child Fatality Review #04-34
Region 1
Spokane Office

Case Overview

This two-month-old Native American female died on October 1, 2004. On August 10, 2004, her mother was brought to Sacred Heart Hospital by her paramour after allegedly jumping or being pushed from a moving vehicle. The mother was 30 weeks pregnant and suffering from critical injuries. The mother was resuscitated, and an emergency cesarean delivery of her infant occurred. The mother died a short time later.

The infant weighed two pounds, 13 ounces at birth. The infant suffered from some pulmonary distress, undeveloped lungs from the premature birth and she was placed on a breathing machine. The infant also evidenced parallel bruising on her right arm, right leg, and right hip that likely occurred in utero as a result of the mother jumping or being pushed from the moving vehicle. These injuries did not occur during the birth according to a treating physician. She was maintained at Sacred Heart for several days when a pediatric neurologist reported that the infant had lost all reflexes and was not registering brain activity. She was removed from life support on October 1, 2004 after Sacred Heart received consent from her family. She died almost two hours later.

The mother and the paramour never engaged in the services that were offered to them. Although they both made a verbal commitment to participate with drug/alcohol intervention as well as domestic violence intervention, neither followed through with the services.

Child Protective Services (CPS) received a high risk emergent referral on July 17, 2003 regarding a domestic violence incident that occurred between the mother and her paramour on July 16, 2003. The report alleged the mother was holding her then three-month-old son while the paramour was assaulting her. The report indicated the three-month-old was knocked from the mother's arms and landed on the couch. The mother and the paramour reportedly started arguing about the paramour's alcohol consumption, and she told him to leave. He began to assault the mother. She called 911 and went to Deaconess Hospital. The mother sustained numerous injuries including a black eye, stitches across her nose, a bruise on her forehead, a cut on her chin, and a significant bite injury to her back. The paramour left the residence before law enforcement responded. He was later charged with domestic violence. It was also reported that both the paramour and the mother smoke marijuana.

A CPS social worker made contact with the mother and her son within two hours of receiving the referral. The mother reported to the social worker that she was not holding her son when this altercation occurred, and her son did not sustain any injury. The family had been receiving services from a Public Health Nurse prior to the CPS report. The mother reported this was the first domestic violence incident with the paramour, and she reported his drinking alcohol contributed to the situation. The apartment manager and neighbors were contacted and several reported they had heard the paramour and the mother argue and/or fight in the past.

The social worker developed a safety plan for the child with the mother on July 21, 2003. The plan stated the mother was not to allow the paramour back into the home until he completed an alcohol assessment, treatment if recommended, and entered into domestic violence counseling. The mother would submit a urinalysis on July 22, 2003, and the paramour's mother was to supervise any visits between the paramour and the baby. The social worker documented that psychological evaluations for the mother, and her paramour could not be referred without a court order due to a local office policy that was in place. On July 30, 2003, the mother tested positive for methamphetamine and marijuana. On August 1, 2003, it was reported by Public Health that the mother had been evicted and moved with her son to the home of her paramour's parents in Cheney, Washington where the paramour was also residing.

The mother and the paramour both signed a voluntary service agreement on August 1, 2003. The plan included the mother and the paramour submitting random urinalyses, participating with a drug/alcohol evaluation and following all treatment recommendations, participating with Safe Start domestic violence program, and maintaining her son in the home of the paternal grandparents. The assigned social worker monitored the parents' participation with the service agreement and the son's safety in the home of his paternal grandparents for approximately six months. By October of 2003, the mother and the paramour were continuing to test positive for marijuana, had refused to follow through with outpatient drug treatment, stopped participation with Safe Start, and refused continuing with Public Health Nursing Services. By the end of 2003 there were no new referrals alleging abuse or neglect to the child, and the case was closed with an overall risk of low to moderate for future child abuse and/or neglect.

On August 10, 2004, a referral was received by a Spokane hospital stating the mother had been badly beaten and was 30 weeks pregnant. Concerns were for the care of her son, then 16-months-old. This referral was screened in alleging neglect. There was an official finding of neglect and abuse made in this case. There was action taken to remove and protect the surviving child. (The mother died as a result of trauma and on October 1, 2004 her infant daughter died.) After CPS received the August 10, 2004 referral, it was learned that the mother was Native American as were her children. Her son was placed in protective custody, where he currently resides, and her paramour has been charged with two counts of second degree murder.

Issues and Recommendations

I. System Issue

A. Issue: Children's Administration employees do not have adequate access to criminal activity records at the local, county, state, or national level that would assist with thorough safety planning and intervention for children.

Recommendation: *Children's Administration should pursue access to local, county, state, and national database systems that record individual's criminal activities to include JUVIS, SCOMIS, NCIC, and FORS programs.*

B. Issue: Spokane County's law enforcement records management system does not include criminal activities of individuals from all jurisdictions within Spokane County. Through this fatality review it was learned that at least five separate jurisdictions do not report to the County's database system.

Recommendation: Notification was sent to all Children's Administration employees in Spokane County on June 27, 2005 informing employees how to obtain accurate records from the various jurisdictions within Spokane County.

C. Issue: Members of this fatality review concurred that there is a lack of certified domestic violence perpetrator treatment providers in the greater Spokane area as well as limited victim resources in the community.

Recommendation: Develop a work plan to identify certified providers and work with the state program managers responsible for certifying the providers in an attempt to increase the resources in the community.

II. Practice Issue

A. Issue: The referral regarding a domestic violence incident between caretakers alleged the mother was the subject of negligent treatment and the father as the subject of physical abuse as the mother was reportedly holding the child while she was assaulted by the father.

Recommendation: In this specific referral, the father should have been listed as the subject of both physical abuse and negligent treatment due to perpetrating the violence that placed the child at risk.

B. Issue: The Native American status of this family was not explored at the time of the first investigation and intervention. If the family had been identified as Native American, a shared decision making process would have occurred with, at a minimum, Spokane Urban Local Indian Child Welfare Advisory Committee (LICWAC).

Recommendation: Per Children's Administration policy 2410, the CPS worker must follow the requirements of WAC 388-15-131 and WAC 388-70-095 in determining if the reported child is Native American. The social worker and supervisor were informed and reviewed the policy.

III. Policy Issue

A. Issue: The review team concurred that the role of the CPS investigator is not clear when attempting interventions with a family in which the children are witnesses, but not physical victims of domestic violence.

Recommendation: Children's Administration needs to develop a statewide policy addressing the practice expectations of Intake social workers and CPS investigators when situations of children witnessing domestic violence occur.

The review team recommends a work plan be developed as a result of this review.

Child Fatality Review #05-02
Region 3
Bellingham Office

Case Overview

This twenty-month-old Caucasian male died on February 6, 2005 due to severe injuries from being "battered." On February 2, 2005, he was taken to the hospital in Bellingham by his caretaker and then airlifted to Harborview Medical Center in critical condition.

This child had been staying with family friends and their two sons for the previous week. The two families were not related. The child's parents were located within a day and notified of the injuries. They confirmed their child had been staying with their friends. The adult male family friend fled the hospital immediately after dropping off the child. A few days later he turned himself in and was arrested. While there was some speculation that the child's injuries may have been older than a week, medical staff and law enforcement determined the injuries were within the time frame when the adult male family friend had been providing care for the child.

When the report of the child's death was originally received, there was some question about what the child's parents knew about the risks involved in leaving him with the family friend. It was later determined through investigation that the parents had left their child with him many times before without problems, and would not have reasonably been able to foresee anything like the consequences that occurred. The result of the investigation for neglect was unfounded for the child's parents.

The family friend was living with his girlfriend and their two sons at the time of this incident. As his girlfriend may have had some knowledge of the child's abuse before his death, she was also investigated for neglect. It was determined through the investigation, which included a polygraph examination, that she did not know of the abuse. The referral was closed as unfounded as to neglect by the girlfriend.

Child Protective Services (CPS) investigated the complaint of abuse to the child by the adult male friend while the child was staying with the friend's family for a week. The investigation resulted in a founded finding against the adult male friend as the caretaker. He eventually pled guilty to a manslaughter charge for this incident.

The referrals listed for this case are all regarding half-siblings to this child. There were no referrals regarding this child as a victim of child abuse and/or neglect by his parents. The only referral involving this child as a victim was in regard to this incident in which he was beaten by the friend of the family.

This child's mother had children from a previous relationship. There were four referrals regarding her daughters. The first was in 1995, and involved a day care staff person who thought that the girl, then three years of age, was afraid to go home. When pursued further, it was determined that she did not appear afraid. The referral was screened as information only and was not assigned. The second referral was in 1998 and concerned dental neglect of this

daughter. It was resolved with medical referrals. The third was in March of 2000. It was reported this child's mother and her current husband were engaged in a domestic violence incident in the presence of the girls. It was investigated and closed as inconclusive. The mother at that time had plans to separate from her husband. In January of 2002, a referral was received with allegations of minor physical abuse by the mother's current husband to his daughter. They were separated at this time, and the mother was living with her father.

The most recent referral involving the mother prior to this incident was in October of 2004. At that time, the mother's daughter was at the home of the mother (although by then the daughter lived next door with her father and her father's new girlfriend). The mother at that time lived in another house on the same property with a new boyfriend and his son, age 16, and their son, the decedent, age one. The daughter from the previous relationship, then 12-years-old, was babysitting the victim for her mother and her mother's boyfriend. The 16-year-old son was present and was allegedly behaving in a sexually aggressive way to daughter. There were no adults present in the home, so the daughter picked up the decedent and went next door to her father's house, ending the incident. This referral was sent to law enforcement, but not assigned to CPS.

The decedent's father also had children from a previous relationship. Their mother has had custody of these children for approximately three years. There are three referrals regarding these children. The first was in 2001 with an allegation of minor physical abuse by their mother to their son, currently sixteen-years-old. It did not screen in for investigation. The second was in May of 2002, after these parents had separated, with an allegation that the father had given their son marijuana. This screened in, was investigated, and determined to be unfounded. The third and last referral on this family prior to this incident was a request from the father for Family Reconciliation Services (FRS), as he needed help in controlling their 16-year-old.

In the adult male friend's family, the only referral prior to this incident came to CPS in January of 1995 when his girlfriend gave birth to her first child, a premature infant weighing only two and a half pounds. The referral was called in by the hospital out of concern that his girlfriend was depressed, and the adult male friend was having trouble with drugs and there was a possibility for domestic violence. The girlfriend, the adult male friend, and the new baby would be living with the girlfriend's family. The referral was screened as information only.

The decedent was born on May 17, 2003. He was the only child of these two parents together, although both his mother and father had other children with previous relationships. His mother had two other children, both girls, and his father had three boys. By the time the decedent was born, those other children were all living with their other parents. There is some evidence that both of his parents struggled with substance dependence issues, which included allegations of dealing drugs during the time they were caring for the decedent. They were not steadily employed and had a rather transient lifestyle. They may have made periodic efforts to "get clean."

Often they let their adult male friend care for their child at his house for several hours or overnight. There was some possibility that this was done in exchange for drugs. The adult male friend lived with his girlfriend and their two biological sons, ages seven and ten. The girlfriend

was employed for the past two years as a pharmacy technician, and the adult male friend was the day time caretaker of the boys. They were very close to his girlfriend's family and sometimes lived with them. There had been no CPS reports on the care of these boys in the last ten years. All reports from the school were that they were good parents. The family knew that the adult male was involved in drugs, and his girlfriend had reportedly given him an ultimatum to get off the drugs or leave the home. In response to this, he enrolled in a methadone program. His drug of choice was oxycontin, but he admitted to some use of methamphetamine. It was during this period that he took the decedent to his house to care for him for a week.

His girlfriend stated the decedent was his responsibility, as he was the one who had agreed to keep him, so the girlfriend did not watch him closely. She said she often did not get home from work until after 6:00 PM as she stopped at her parents to pick up the boys after work, and the decedent was often asleep by that time. The girlfriend said the decedent had had bruises on his face and back, when he arrived earlier in the week. She said that during the week the decedent had seemed not to feel well, and she thought he must just be depressed. She said that the child missed his "mommy" and that was another reason why she did not get involved with him--because he might "latch onto" her (as a mother) and not obey his own mother. The girlfriend said on February 2, 2005, she told the adult male she thought the child was "disturbed," and they should call CPS, but he said no because CPS might think that he had done something. He left at 5:00 AM for the methadone clinic each day, and often would take the child with him. On February 4, 2005, the girlfriend said that he had carried the child out in a blanket that morning as she was leaving for work. She did not know where he was taking the child, but assumed it was back to his parents. It was that day he left the child at the Bellingham hospital with severe injuries. Later, during the police investigation, the girlfriend passed a polygraph examination indicating she did not know that he had been abusing the child. Eventually the children who had been placed in protective custody, were returned to the girlfriend's custody. He pled guilty to manslaughter. He remains in prison.

Issues and Recommendations

I. Practice Issue

A. Issue: The referral in October 2004 involving a 16-year-old boy sexually harassing a 12-year-old girl in a situation with no adult caregivers was incorrectly coded. It was written as a "third party" referral. The girl was marked as a victim, but no subject was listed. The referral was correctly sent to law enforcement.

Recommendation: *Follow policy. This type of situation should have been considered as possible neglect with all the children as victims, and the parent as the subject.*

Child Fatality Review #05-03
Region 2
Ellensburg Office

Case Overview

This one-month-old Caucasian female was found deceased at her home on March 23, 2005. There was no specific information related to the death at that time, and the autopsy that was performed was inconclusive. Both parents tested positive for methamphetamines. The mother agreed to voluntarily place her children with the Department at that time.

Per the mother's statement, at about 1:00 AM the baby became fussy, and she got up and held the baby and calmed her down. At approximately 4:00 AM she went to check on the baby again, and she was no longer alive. Per the coroner's autopsy report, reasonable possibilities for the cause of death include Sudden Infant Death Syndrome (SIDS) and suffocation/overlay. The cause and manner of death are listed as undetermined. The Department has an extensive history with this family including substance abuse, domestic violence, sexual abuse, neglect, etc. with two founded referrals for physical neglect. The Department received reports during the week of March 16, 2005 concerning the children residing in the home, and Child Protective Services (CPS) attempted to contact the mother. An information only referral was also received stating the deceased child was in need of medical follow-up. The parents took the child to the physician on March 17, 2005. Minimal weight gain was noted and the child had thrush. A prescription was given for the thrush.

On March 21, 2005, the social worker went to the home. There were two families living there- the family of the decedent and another family. The social worker took two of the children from the other family into custody including a three-year-old female with severe head lice, dental carries, and ring worm, and a four-month-old infant suffering from failure to thrive secondary to neglect.

On March 23, 2005, a referral was made to the Department by the Kittitas Police Department (KPD) reporting the one-month-old infant was deceased, and this had occurred sometime in the early morning hours of March 23rd. There was no specific information related to the death at that time, and the autopsy that was performed was inconclusive. Both parents tested positive for methamphetamines. The mother agreed to voluntarily place her children with the Department at that time. It was determined there were no appropriate family members to care for the children. The mother's step father sexually abused the mother, and the grandmother would not leave him to care for the children. The mother's brother has also allegedly sexually abused one of the mother's children in the past.

The mother has worked very hard to comply with the expectations of the Department, however, she seems to minimize the issues that led to her involvement with CPS. She has a very complex history both as a child and adult. She reports sexual abuse by her step father and subsequently, her mother not protecting her and choosing the step father over herself. She has been in at least two relationships with men that the Department is aware of in which domestic violence was apparent. She has done a good job of overcoming this and feels that she will be able to have relationships in the future that are more equalized. The mother is currently working two jobs to

support herself. Historically, the mother has chosen to work and is hesitant to accept assistance from the state or elsewhere.

Per a conversation the social worker had with a police department representative approximately one year ago, the mother works and the men in her life "feed off her" and watch her children while she works. He has had concern about the individuals that the mother allows access to her children, however, he did not feel that the concern had warranted a referral or removal of the children. He stated that he had attempted to set up safe housing for the mother more than once, and she did not follow through.

The mother currently has completed a substance evaluation and intensive outpatient treatment. She has supervised visits with her children three times a week. The mother stops in to see the assigned worker at least a couple of times per week and/or calls, almost on a daily basis. She is very distraught and feels that she "needs" her children. Although the mother is reassured that she has a great amount of visitation with her children compared to other cases, she feels that it is not enough. The mother has completed a mental health evaluation, however, she has not followed through with the recommended counseling due to her scheduling conflicts with work, visits, etc.

The social worker is not aware as to whether or not she has fulfilled the domestic violence assessment requirement of the Individual Service Plan at this time. The social worker has made a referral for an interactive psychological parenting evaluation that is pending approval from supervisors. The foster parent reports that the mother allows her children to have inappropriate CDs, etc. and that when there are phone calls, the mother doesn't seem to be satisfied unless the kids become upset that they miss her. The mother struggles with her role as a parent and rather seems to act as more of a peer to her children.

The allegation of negligent treatment or maltreatment is founded based on random urinalysis (UA) done on both parents that were positive for methamphetamine at the time. The surviving siblings were placed out of the home. The children were not seen by a doctor or dentist in the last two years and had severe dental problems.

An investigation was conducted, and a safety plan was set forth to include drug screening for methamphetamine and court involvement if the death was determined non-accidental.

A review of the electronic records reveal that services were offered to the mother, but she did not fully participate in them. The mother did complete two UAs upon the request of the Department, and they were both negative. The mother did not fully comply with the following services: completing a drug/alcohol evaluation, getting the children into counseling with Central Washington Comprehensive Mental Health (CWCMH), and following through with Home Based Services (HBS) through the Division of Children and Family Services (DCFS). Most recently, after the surviving siblings have been placed, she has complied with mental health services and with substance abuse services by completing UAs and an intensive out-patient treatment.

The three siblings are currently in foster care. The oldest child’s father has no contact with the child and is not involved in the current proceedings. The two younger children’s father has

relocated to Alaska shortly after the death. He wishes for the children to be placed with his sister, and the social worker has worked on an Interstate Compact on the Placement of Children (ICPC) at the father's request. To date, a dependency has only been established as to the mother and the father has appealed or contested any proceedings. To date, the social worker is not aware of any services the father has engaged in.

Issues and Recommendations

I. System Issue

A. Issue: Prevalent methamphetamine use in the community.

Recommendation: *Continued community education on methamphetamine use; Continue support of the Methamphetamine Action Team in Kittitas County; Support and Distribute, Drug Endangered Children (DEC) Investigation Handbook to local DCFS offices and community for further education on methamphetamine.*

B. Issue: Communication between KPD and Children's Administration, Ellensburg Office.

Recommendation: *Officers from the KPD and Ellensburg DCFS social workers attend co-training on topics to include, but not limited to: joint investigations, mandatory reporting laws; KPD and the Ellensburg DCFS establish a written working agreement; KPD and the Ellensburg DCFS establish a quarterly meeting at a location later to be determined.*

II. Practice Issue

A. Issue: Intake screening

Recommendation: *The review team recommends that shared decision staffing occur between the intake worker, supervisor and area administrator whenever there is a referral on a chronic referring family (three referrals in the prior year; four in prior two years; five in prior three years; two or more founded allegations in the past two to six CPS referrals) and training on intake risk assessment.*